Resident _____ Numeric Identifier _____

SECTION T. THERAPY SUPPLEMENT FOR MEDICARE PPS

Attachment 4.19D
Page 9 of 12

1. SPECIAL TREATMENTS AND PROCEDURES

a. **RECREATION THERAPY**—*Enter number of days and total minutes of recreation therapy administered (for at least 15 minutes a day) in the last 7 days (Enter 0 if none)*

	DAYS (A)	MIN (B)
(A) = # of days administered for 15 minutes or more (B) = total # of minutes provided in last 7 days		

Skip unless this is a Medicare 5 day or Medicare readmission/ return assessment.

b. **ORDERED THERAPIES**—*Has physician ordered any of following therapies to begin in FIRST 14 days of stay—physical therapy, occupational therapy, or speech pathology service?*
0. No 1. Yes

If not ordered, skip to item 2

c. Through day 15, provide an estimate of the number of days when at least 1 therapy service can be expected to have been delivered.

d. Through day 15, provide an estimate of the number of therapy minutes (across the therapies) that can be expected to be delivered?

2. WALKING WHEN MOST SELF SUFFICIENT

Complete item 2 if ADL self-performance score for TRANSFER (G.1.b.A) is 0,1,2, or 3 AND at least one of the following are present:

- Resident received physical therapy involving gait training (P.1.b.c)
- Physical therapy was ordered for the resident involving gait training (T.1.b)
- Resident received nursing rehabilitation for walking (P.3.f)
- Physical therapy involving walking has been discontinued within the past 180 days

Skip to item 3 if resident did not walk in last 7 days

(FOR FOLLOWING FIVE ITEMS, BASE CODING ON THE EPISODE WHEN THE RESIDENT WALKED THE FARTHEST WITHOUT SITTING DOWN. INCLUDE WALKING DURING REHABILITATION SESSIONS.)

a. **Furthest distance walked** without sitting down during this episode.

0. 150+ feet
1. 51-149 feet
2. 26-50 feet
3. 10-25 feet
4. Less than 10 feet

b. **Time walked** without sitting down during this episode.

0. 1-2 minutes
1. 3-4 minutes
2. 5-10 minutes
3. 11-15 minutes
4. 16-30 minutes
5. 31+ minutes

c. **Self-Performance in walking** during this episode.

0. *INDEPENDENT*—No help or oversight
1. *SUPERVISION*—Oversight, encouragement or cueing provided
2. *LIMITED ASSISTANCE*—Resident highly involved in walking; received physical help in guided maneuvering of limbs or other nonweight bearing assistance
3. *EXTENSIVE ASSISTANCE*—Resident received weight bearing assistance while walking

d. **Walking support provided** associated with this episode (code regardless of resident's self-performance classification).

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist

e. **Parallel bars** used by resident in association with this episode.

0. No 1. Yes

3. CASE MIX GROUP

Medicare _____ State _____

TN #04-001 APPROVAL DATE APR 29 2004

SUPERSEDES EFFECTIVE DATE 01/08/04

SECTION V. RESIDENT ASSESSMENT PROTOCOL SUMMARY

Resident's Name:	Medical Record No.:

1. Check if RAP is triggered.
2. For each triggered RAP, use the RAP guidelines to identify areas needing further assessment. Document relevant assessment information regarding the resident's status.
   - Describe:
     — Nature of the condition (may include presence or lack of objective data and subjective complaints).
     — Complications and risk factors that affect your decision to proceed to care planning.
     — Factors that must be considered in developing individualized care plan interventions.
     — Need for referrals/further evaluation by appropriate health professionals.
   - Documentation should support your decision-making regarding whether to proceed with a care plan for a triggered RAP and the type(s) of care plan interventions that are appropriate for a particular resident.
   - Documentation may appear anywhere in the clinical record (e.g., progress notes, consults, flowsheets, etc.).
3. Indicate under the Location of RAP Assessment Documentation column where information related to the RAP assessment can be found.
4. For each triggered RAP, indicate whether a new care plan, care plan revision, or continuation of current care plan is necessary to address the problem(s) identified in your assessment. The Care Planning Decision column must be completed within 7 days of completing the RAI (MDS and RAPs).

A. RAP PROBLEM AREA	(a) Check if triggered	Location and Date of RAP Assessment Documentation	(b) Care Planning Decision—check if addressed in care plan
1. DELIRIUM	☐		☐
2. COGNITIVE LOSS	☐		☐
3. VISUAL FUNCTION	☐		☐
4. COMMUNICATION	☐		☐
5. ADL FUNCTIONAL/ REHABILITATION POTENTIAL	☐		☐
6. URINARY INCONTINENCE AND INDWELLING CATHETER	☐		☐
7. PSYCHOSOCIAL WELL-BEING	☐		☐
8. MOOD STATE	☐		☐
9. BEHAVIORAL SYMPTOMS	☐		☐
10. ACTIVITIES	☐		☐
11. FALLS	☐		☐
12. NUTRITIONAL STATUS	☐		☐
13. FEEDING TUBES	☐		☐
14. DEHYDRATION/FLUID MAINTENANCE	☐		☐
15. DENTAL CARE	☐		☐
16. PRESSURE ULCERS	☐		☐
17. PSYCHOTROPIC DRUG USE	☐		☐
18. PHYSICAL RESTRAINTS	☐		☐

B. _____
1. Signature of RN Coordinator for RAP Assessment Process

2. ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year)

_____
3. Signature of Person Completing Care Planning Decision

4. ☐☐ – ☐☐ – ☐☐☐☐ (Month – Day – Year)

Attachment 4.19D

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0)

Key:

- ● = One item required to trigger
- ❷ = Two items required to trigger
- ✱ = One of these three items, plus at least one other item required to trigger
- ⓐ = When both ADL triggers present, maintenance takes precedence

Proceed to RAP Review once triggered

MDS ITEM		CODE	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL-Rehabilitation Trigger A @	ADL-Maintenance Trigger B @	Urinary Incontinence and Indwelling Catheter	Psychosocial Well-Being	Mood State	Behavioral Symptoms	Activities Trigger A	Activities Trigger B	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints	MDS ITEM
B2a	Short term memory	1		●																			B2a
B2b	Long term memory	1		●																			B2b
B4	Decision making	1,2,3		●																			B4
B4	Decision making	4					●																B4
B5a to B5f	Indicators of delirium	2	●																	●			B5a to B5f
B6	Change in cognitive status	2	●																	●			B6
C1	Hearing	1,2,3			●																		C1
C4	Understanding others	1,2,3			●																		C4
C5	Understand others	1,2,3		●																			C5
C7	Change in communication	2																		●			C7
D1	Vision	1,2,3			●																		D1
D2a	Side vision problem	2			●																		D2a
E1a to E1p	Indicators of depression, anxiety, sad mood	1,2									●												E1a to E1p
E1b	Psychomotor retardation	1,2																		●			E1b
E1p	Withdrawal from activities	1,2							●														E1p
E2	Mood persistence	1,2									●												E2
E3	Change in Mood	2	●																	●			E3
E4aA	Wandering	1,2,3													●								E4aA
E4aA - E4eA	Behavioral symptoms	1,2,3										●											E4aA - E4eA
E5	Change in behavioral symptoms	2										●											E5
E5	Change in behavioral symptoms	2	●																	●			E5
F1d	Establishes own goals	✓						●															F1d
F2a to F2d	Unsettled relationships	✓						●															F2a to F2d
F3a	Sorting of past roles	✓						●															F3a
F3b	Lost roles	✓						●															F3b
F3c	Daily routine disrupt	✓						●															F3c
G1aA - G1jA	ADL self-performance	1,2,3,4				●																	G1aA - G1jA
G1eA	Bed mobility	2,3,4,8																	●				G1eA
G2A	Bathing	1,2,3,4				●																	G2A
G2b	Balance while sitting	1,2,8																		●			G2b
G6a	Bedfast	✓																	●				G6a
G6a,b	Repition, staff believe capable	✓				●																	G6a,b
H1a	Bowel incontinence	1,2,3,4																	●				H1a
H1b	Bladder incontinence	2,3,4						●															H1b
H2b	Constipation	✓																		●			H2b
H2d	Fecal impaction	✓																		●			H2d
H3c,d,e	Catheter use	✓							●														H3c,d,e
H3g	Use of condom/pouch	✓							●														H3g
I1i	Hypertension	✓																		●			I1i
I1j	Peripheral vascular disease	✓																	●				I1j
I1ee	Depression	✓																		●			I1ee
I1l	Cataracts	✓			●																		I1l
I1ll	Glaucoma	✓			●																		I1ll
I2	UTI	✓																●					I2
I3	Dehydration diagnosis	276.5																●					I3
J1a	Weight fluctuation	✓																●					J1a
J1c	Dehydrated	✓																●					J1c
J1d	Insufficient fluid	✓																●					J1d
J1f	Dizziness	✓													●					●			J1f
J1k	Feyer	✓																●					J1k
J1l	Hallucinations	✓																		●			J1l
J1j	Internal bleeding	✓																●					J1j
J1k	Lung aspirations	✓																		●			J1k
J1m	Syncope	✓																		●			J1m

TN #04-001 APPROVAL DATE MAR 29 2004

SUPERSEDES

RESIDENT ASSESSMENT PROTOCOL TRIGGER LEGEND FOR REVISED RAPS (FOR MDS VERSION 2.0)

Key:
- ● = One item required to trigger
- ❷ = Two items required to trigger
- ✱ = One of these three items, plus at least one other item required to trigger
- ⓐ = When both ADL triggers present, maintenance takes precedence

Proceed to RAP Review once triggered

MDS ITEM	CODE	Delirium	Cognitive Loss/Dementia	Visual Function	Communication	ADL-Rehabilitation Trigger A ⓐ	ADL-Maintenance Trigger B ⓐ	Urinary Incontinence and Indwelling Catheter	Psychosocial Well-Being	Mood State	Behavioral Symptoms	Activities Trigger A	Activities Trigger B	Falls	Nutritional Status	Feeding Tubes	Dehydration/Fluid Maintenance	Dental Care	Pressure Ulcers	Psychotropic Drug Use	Physical Restraints	MDS ITEM
J1h	Unsteady gait	✓																	●			J1h
J4a,b	Fall	✓												●					●			J4a,b
J4c	Hip fracture	✓																	●			J4c
K1b	Swallowing problem	✓																	●			K1b
K1c	Mouth pain	✓																●				K1c
K3a	Weight loss	1													●							K3a
K4a	Tube feeding	✓													●							K4a
K4c	Lesion 2/4 to mouth	✓													●							K4c
K5a	Parenteral feeding	✓													●		●					K5a
K5b	Feeding tube	✓														●	●					K5b
K5c	Mechanically altered	✓													●							K5c
K5d	Syringe feeding	✓													●							K5d
K5e	Therapeutic diet	✓													●							K5e
L1a,c,d,e	Dental	✓																●				L1a,c,d,e
L3i	Daily cleaning teeth	Must ✓																●				L3i
M2a	Pressure ulcer	1,2,3,4													●							M2a
M2a	Pressure ulcer	1,2,3,4																	●			M2a
M3	Previous pressure ulcer	1																	●			M3
M4a	Impaired tactile sense	✓																	●			M4a
N1a	Awake morning	✓												●								N1a
N2	Involved in activities	0												●								N2
N2	Involved in activities	2,3									●											N2
N5a,b	Prefers change in daily routine	1,2									●											N5a,b
O4a	Antipsychotics	1-7																		✱		O4a
O4b	Antianxiety	1-7												●						✱		O4b
O4c	Antidepressants	1-7												●						✱		O4c
O4e	Diuretic	1-7															●					O4e
P4c	Trunk restraint	1,2												●							●	P4c
P4c	Trunk restraint	2																	●			P4c
P4d	Limb restraint	1,2																			●	P4d
P4e	Chair prevents rising	1,2																			●	P4e

ACTION: Final | EXISTING | Numeric Identifier | DATE: 12/29/2003 10:09 AM

APPENDIX PPS
3101.5-3-40

MINIMUM DATA SET (MDS) — VERSION 2.0

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

Attachment 4.19D
Page 1 of 1

DISCHARGE TRACKING FORM **[*do not use for temporary visits home*]**

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME ⊙	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	GENDER ⊙	1. Male 2. Female
3.	BIRTHDATE ⊙	Month — Day — Year
4.	RACE/ ETHNICITY ⊙	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
5.	SOCIAL SECURITY AND MEDICARE NUMBERS ⊙ [C in 1st box if non med. no.]	a. Social Security Number b. Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO. ⊙	a. State No. b. Federal No.
7.	MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient] ⊙	
8.	REASONS FOR ASSESS-MENT	[Note—Other codes do not apply to this form] a. Primary reason for assessment 6. Discharged—return not anticipated 7. Discharged—return anticipated 8. Discharged prior to completing initial assessment

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Sections	Date
a.		
b.		
c.		

SECTION AB. DEMOGRAPHIC INFORMATION

[Complete only for stays less than 14 days] **(AABa=8)**

1.	DATE OF ENTRY	*Date the stay began. Note — Does not include readmission if record was closed at time of temporary discharge to hospital, etc. In such cases, use prior admission date* Month — Day — Year
2.	ADMITTED FROM (AT ENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

6.	MEDICAL RECORD NO.	

SECTION R. ASSESSMENT/DISCHARGE INFORMATION

3.	DISCHARGE STATUS	a. *Code for resident disposition upon discharge* 1. Private home/apartment with no home health services 2. Private home/apartment with home health services 3. Board and care/assisted living 4. Another nursing facility 5. Acute care hospital 6. Psychiatric hopital, MR/DD facility 7. Rehabilitation hospital 8. Deceased 9. Other b. *Optional State Code*
4.	DISCHARGE DATE	*Date of death or discharge* Month — Day — Year

⊙ = Key items for computerized resident tracking

APR 2 9 2004

[ ] = When box blank, must enter number or letter [a.] = When letter in box, check if condition applies

IN #04-001 APPROVAL DATE

APPENDIX pa(16555) pa(16389) d(545301) pa(56456)

SUPERSEDES

ACTION: Final | EXISTING APPENDIX 5101.5-3-40 | Numeric Identifier | DATE: 12/29/2003 10:09 AM

MINIMUM DATA SET (MDS) — *VERSION 2.0*

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

Attachment 4.19D

Page 1 of 1

REENTRY TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME ⊙	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	GENDER ⊙	1. Male 2. Female
3.	BIRTHDATE ⊙	Month — Day — Year
4.	RACE/ ETHNICITY ⊙	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
5.	SOCIAL SECURITY ⊙ AND MEDICARE NUMBERS ⊙ [C in 1st box if non med. no.]	a. Social Security Number — — b. Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO. ⊙	a. State No. b. Federal No.
7.	MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient] ⊙	
8.	REASONS FOR ASSESS-MENT	[Note—Other codes do not apply to this form] a. Primary reason for assessment 9. Reentry

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

Signature and Title	Sections	Date
a.		
b.		
c.		

SECTION A. IDENTIFICATION AND BACKGROUND INFORMATION

4a.	DATE OF REENTRY	Date of reentry: Month — Day — Year
4b.	ADMITTED FROM (AT REENTRY)	1. Private home/apt. with no home health services 2. Private home/apt. with home health services 3. Board and care/assisted living/group home 4. Nursing home 5. Acute care hospital 6. Psychiatric hospital, MR/DD facility 7. Rehabilitation hospital 8. Other
6.	MEDICAL RECORD NO.	

⊙ = Key items for computerized resident tracking

= When box blank, must enter number or letter = When letter in box, check if condition applies

TN #04-001 APPROVAL DATE APR 29 2004

SUPERSEDES

ACTION: Final **MINIMUM DATA SET (MDS) – VERSION 2.0** DATE: 12/29/2003 10:09 AM

APPENDIX
S1013-320

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

Correction Request Form

Use this form (1) to request correction of error(s) in an MDS assessment record or error(s) in an MDS Discharge or Reentry Tracking form record that has been previously accepted into the State MDS database, (2) to identify the inaccurate record, and (3) to attest to the correction request. A correction request can be made to either MODIFY or INACTIVATE a record.

Attachment 4.19D
Page 1 of 1

TO MODIFY A RECORD IN THE STATE DATABASE:
1. Complete a new corrected assessment form or tracking form. Include all the items on the form, not just those in need of correction;
2. Complete and attach this Correction Request Form to the corrected assessment or tracking form;
3. Create a new electronic record including the corrected assessment or tracking form AND the Correction Request Form; and
4. Electronically submit the new record (as in #3) to the MDS database at the State.

TO INACTIVATE A RECORD IN THE STATE DATABASE:
1. Complete this correction request form;
2. Create an electronic record of the Correction Request Form; and
3. Electronically submit this Correction Request record to the MDS database at the State.

PRIOR RECORD SECTION.
THIS SECTION IDENTIFIES THE ASSESSMENT OR TRACKING FORM THAT IS IN ERROR. (***In this section, reproduce the information EXACTLY as it appeared in the erroneous record, even if the information is wrong. This information is necessary in order to locate the record in the State database.***)

Prior AA1.	RESIDENT NAME	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
Prior AA2.	GENDER	1. Male 2. Female
Prior AA3.	BIRTHDATE	Month – Day – Year
Prior AA5.	SOCIAL SECURITY	a. Social Security Number
Prior AA8.	REASONS FOR ASSESSMENT	a. Primary reason for assessment ASSESSMENT (Complete Prior Date item Prior A3a *ONLY*) 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 10. Significant correction of prior quarterly assessment 0. *NONE OF ABOVE* DISCHARGE TRACKING (Complete Prior Date item Prior R4 *ONLY*) 6. Discharged—return not anticipated 7. Discharged—return anticipated 8. Discharged prior ro completing initial assessment REENTRY TRACKING (Complete Prior Date item Prior A4a *ONLY*) 9. Rentry b. ***Codes for assessments required for Medicare PPS or the State*** *1. Medicare 5 day assessment* *2. Medicare 30 day assessment* *3. Medicare 60 day assessment* *4. Medicare 90 day assessment* *5. Medicare readmission/return assessment* *6. Other state required assessment* *7. Medicare 14 day assessment* *8. Other Medicare required assessment*
	PRIOR DATE	(***Complete one only***) Complete Prior A3a if Primary Reason (Prior AA8a) equals 1, 2, 3, 4, 5, 10, or 0. Complete Prior R4 if Primary Reason (Prior AA8a) equals 6, 7, or 8. Complete Prior A4a if Primary Reason (Prior AA8a) equals 9.
Prior A3.	ASSESSMENT REFERENCE DATE	a. *Last day of MDS observation period* Month – Day – Year
Prior R4.	DISCHARGE DATE	*Date of discharge* Month – Day – Year
Prior A4a.	DATE OF REENTRY	*Date of reentry* Month – Day – Year

AT3.	REASONS FOR MODIFICATION	(***If AT2=1, check at least one of the following reasons; check all that apply, then skip to AT5***) a. Transcription error b. Data entry error c. Software product error d. Item coding error e. Other error *If "Other" checked, please specify:* _____
AT4.	REASONS FOR INACTIVATION	(***If AT2=2, check at least one of the following reasons; check all that apply.***) a. Test record submitted as production record b. Event did not occur c. Inadvertent submission of inappropriate record d. Other reason requiring inactivation *If "Other" checked, please specify:* _____

RN COORDINATOR ATTESTATION OF COMPLETION

AT5.	ATTESTING INDIVIDUAL NAME	a. (First) b. (Last) c. (Title)
	SIGNATURE	
AT6.	ATTESTATION DATE	Month – Day – Year

AT7. ATTESTATION OF ACCURACY AND SIGNATURES OF PERSONS WHO CORRECT A PORTION OF ASSESSMENT OR TRACKING INFORMATION

I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.

	Signature and Title	Attestation Date
a.		
b.		
c.		
d.		
e.		
f.		

CORRECTION ATTESTATION SECTION.
COMPLETE THIS SECTION TO EXPLAIN AND ATTEST TO THE CORRECT REQUEST

AT1.	ATTESTATION SEQUENCE NUMBER	(*Enter total number of attestations for this record, including the present one*)
AT2.	ACTION REQUESTED	1. MODIFY record in error (*Attach and submit a COMPLETE assessment or tracking form. Do NOT submit the corrected items ONLY.* ***Proceed to item AT3 below.***) 2. INACTIVE record in error. (*Do NOT submit an assessment or tracking form. Submit the correction request only.* ***Skip to item AT4.***)

OH-001

APPROVAL DATE APR 2 9 2004

SUPERSEDES

ACTION: Final

Numeric Identifier: DATE: 12/29/2003 10:09 AM

APPENDIX PP-3101.5-3.40

MINIMUM DATA SET (MDS) — VERSION 2.0

FOR NURSING HOME RESIDENT ASSESSMENT AND CARE SCREENING

Attachment 4.19D

Page 1 of 5

BASIC ASSESSMENT TRACKING FORM

SECTION AA. IDENTIFICATION INFORMATION

1.	RESIDENT NAME ⊙	a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)
2.	GENDER ⊙	1. Male 2. Female
3.	BIRTHDATE ⊙	Month Day Year
4.	RACE/ETHNICITY ⊙	1. American Indian/Alaskan Native 2. Asian/Pacific Islander 3. Black, not of Hispanic origin 4. Hispanic 5. White, not of Hispanic origin
5.	SOCIAL SECURITY AND MEDICARE NUMBERS ⊙ [C in 1st box if non med. no.]	a. Social Security Number b. Medicare number (or comparable railroad insurance number)
6.	FACILITY PROVIDER NO. ⊙	a. State No. b. Federal No.
7.	MEDICAID NO. ["+" if pending, "N" if not a Medicaid recipient] ⊙	
8.	REASONS FOR ASSESSMENT	[Note—Other codes do not apply to this form] a. Primary reason for assessment 1. Admission assessment (required by day 14) 2. Annual assessment 3. Significant change in status assessment 4. Significant correction of prior full assessment 5. Quarterly review assessment 10. Significant correction of prior quarterly assessment 0. *NONE OF ABOVE* b. *Codes for assessments required for Medicare PPS or the State* *1. Medicare 5 day assessment* *2. Medicare 30 day assessment* *3. Medicare 60 day assessment* *4. Medicare 90 day assessment* *5. Medicare readmission/return assessment* *6. Other state required assessment* *7. Medicare 14 day assessment* *8. Other Medicare required assessment*

9. Signatures of Persons who Completed a Portion of the Accompanying Assessment or Tracking Form		
I certify that the accompanying information accurately reflects resident assessment or tracking information for this resident and that I collected or coordinated collection of this information on the dates specified. To the best of my knowledge, this information was collected in accordance with applicable Medicare and Medicaid requirements. I understand that this information is used as a basis for ensuring that residents receive appropriate and quality care, and as a basis for payment from federal funds. I further understand that payment of such federal funds and continued participation in the government-funded health care programs is conditioned on the accuracy and truthfulness of this information, and that I may be personally subject to or may subject my organization to substantial criminal, civil, and/or administrative penalties for submitting false information. I also certify that I am authorized to submit this information by this facility on its behalf.		
Signature and Title	Sections	Date
a.		
b.		
c.		
d.		
e.		
f.		
g.		
h.		
i.		
j.		
k.		
l.		

GENERAL INSTRUCTIONS

Complete this information for submission with all full and quarterly assessments (Admission, Annual, Significant Change, State or Medicare required assessments, or Quarterly Reviews, etc.)

⊙ = Key items for computerized resident tracking

= When box blank, must enter number or letter a. = When letter in box, check if condition applies

IN #04-001 APPROVAL DATE APR 29 2004

SUPERSEDES

MDS MEDICARE PPS ASSESSMENT FORM (VERSION JULY 2002)

Numeric Identifier _____

AB5. RESIDENTIAL HISTORY 5 YEARS PRIOR TO ENTRY — *(Check all settings resident lived in during 5 years prior to date of entry.)*
- a. Prior stay at this nursing home
- b. Stay in other nursing home
- c. Other residential facility—board and care home, assisted living, group home
- d. MH/psychiatric setting
- e. MR/DD setting
- f. *NONE OF ABOVE*

A1. RESIDENT NAME — a. (First) b. (Middle Initial) c. (Last) d. (Jr/Sr)

A2. ROOM NUMBER

A3. ASSESSMENT REFERENCE DATE — a. Last day of MDS observation period (Month / Day / Year)

A4a DATE OF REENTRY — **Date of reentry from most recent temporary discharge to a hospital in last 90 days (or since last assessment or admission if less than 90 days)** (Month / Day / Year)

A5. MARITAL STATUS — 1. Never married 2. Married 3. Widowed 4. Separated 5. Divorced

A6. MEDICAL RECORD NO.

A10. ADVANCED DIRECTIVES — *(For those items with supporting documentation in the medical record, check all that apply)*
b. Do not resuscitate c. Do not hospitalize

B1. COMATOSE — *(Persistent vegetative state/no discernible consciousness)* 0. No 1. Yes *(If Yes, skip to Section G)*

B2. MEMORY — *(Recall of what was learned or known)*
- a. Short-term memory OK—seems/appears to recall after 5 minutes — 0. Memory OK 1. Memory problem
- b. Long-term memory OK—seems/appears to recall long past — 0. Memory OK 1. Memory problem

B3. MEMORY/ RECALL ABILITY — *(Check all that resident was normally able to recall during last 7 days)*
- a. Current season
- b. Location of own room
- c. Staff names/faces
- d. That he/she is in a nursing home
- e. *NONE OF ABOVE* are recalled

B4. COGNITIVE SKILLS FOR DAILY DECISION-MAKING — *(Made decisions regarding tasks of daily life)*
0. *INDEPENDENT*—decisions consistent/reasonable
1. *MODIFIED INDEPENDENCE*—some difficulty in new situations only
2. *MODERATELY IMPAIRED*—decisions poor; cues/supervision required
3. *SEVERELY IMPAIRED*—never/rarely made decisions

B5. INDICATORS OF DELIRIUM—PERIODIC DISORDERED THINKING/ AWARENESS — *(Code for behavior in the last 7 days.)* **[Note: Accurate assessment requires conversations with staff and family who have direct knowledge of resident's behavior over this time].**
0. Behavior not present
1. Behavior present, not of recent onset
2. Behavior present, over last 7 days appears different from resident's usual functioning (e.g., new onset or worsening)

- a. EASILY DISTRACTED—(e.g., difficulty paying attention; gets sidetracked)
- b. PERIODS OF ALTERED PERCEPTION OR AWARENESS OF SURROUNDINGS—(e.g., moves lips or talks to someone not present; believes he/she is somewhere else; confuses night and day)
- c. EPISODES OF DISORGANIZED SPEECH—(e.g., speech is incoherent, nonsensical, irrelevant, or rambling from subject to subject; loses train of thought)
- d. PERIODS OF RESTLESSNESS—(e.g., fidgeting or picking at skin, clothing, napkins, etc; frequent position changes; repetitive physical movements or calling out)
- e. PERIODS OF LETHARGY—(e.g., sluggishness; staring into space; difficult to arouse; little body movement)
- f. MENTAL FUNCTION VARIES OVER THE COURSE OF THE DAY—(e.g., sometimes better, sometimes worse; behaviors sometimes present, sometimes not)

TN

C4. MAKING SELF UNDERSTOOD
0. *UNDERSTOOD*
1. *USUALLY UNDERSTOOD*—difficulty finding words or finishing thoughts
2. *SOMETIMES UNDERSTOOD*—ability is limited to making concrete requests
3. *RARELY/NEVER UNDERSTOOD*

C6. ABILITY TO UNDERSTAND OTHERS — *(Understanding verbal information content—however able)*
0. *UNDERSTANDS*
1. *USUALLY UNDERSTANDS*—may miss some part/intent of message
2. *SOMETIMES UNDERSTANDS*—responds adequately to simple, direct communication
3. *RARELY/NEVER UNDERSTANDS*

D1. VISION — *(Ability to see in adequate light and with glasses if used)*
0. *ADEQUATE*—sees fine detail, including regular print in newspapers/books
1. *IMPAIRED*—sees large print, but not regular print in newspapers/ books
2. *MODERATELY IMPAIRED*—limited vision; not able to see newspaper headlines, but can identify objects
3. *HIGHLY IMPAIRED*—object identification in question, but eyes appear to follow objects
4. *SEVERELY IMPAIRED*—no vision or sees only light, colors, or shapes; eyes do not appear to follow objects

E1. INDICATORS OF DEPRESSION, ANXIETY, SAD MOOD — *(Code for indicators observed in last 30 days, irrespective of the assumed cause)*
0. Indicator not exhibited in last 30 days
1. Indicator of this type exhibited up to five days a week
2. Indicator of this type exhibited daily or almost daily (6, 7 days a week)

VERBAL EXPRESSIONS OF DISTRESS
- a. Resident made negative statements—e.g., *"Nothing matters; Would rather be dead; What's the use; Regrets having lived so long; Let me die"*
- b. Repetitive questions—e.g., *"Where do I go; What do I do?"*
- c. Repetitive verbalizations—e.g., calling out for help, *("God help me")*
- d. Persistent anger with self or others—e.g., easily annoyed, anger at placement in nursing home; anger at care received
- e. Self deprecation—e.g., *"I am nothing; I am of no use to anyone"*
- f. Expressions of what appear to be unrealistic fears—e.g., fear of being abandoned, left alone, being with others
- g. Recurrent statements that something terrible is about to happen—e.g., believes he or she is about to die, have a heart attack
- h. Repetitive health complaints—e.g., persistently seeks medical attention, obsessive concern with body functions
- i. Repetitive anxious complaints/concerns (non-health related) e.g., persistently seeks attention/ reassurance regarding schedules, meals, laundry, clothing, relationship issues

SLEEP-CYCLE ISSUES
- j. Unpleasant mood in morning
- k. Insomnia/change in usual sleep pattern

SAD, APATHETIC, ANXIOUS APPEARANCE
- l. Sad, pained, worried facial expressions—e.g., furrowed brows
- m. Crying, tearfulness
- n. Repetitive physical movements—e.g., pacing, hand wringing, restlessness, fidgeting, picking

LOSS OF INTEREST
- o. Withdrawal from activities of interest—e.g., no interest in long standing activities or being with family/friends
- p. Reduced social interaction

E2. MOOD PERSISTENCE — **One or more indicators of depressed, sad or anxious mood were not easily altered by attempts to "cheer up", console, or reassure the resident over last 7 days**
0. No mood indicators 1. Indicators present, easily altered 2. Indicators present, not easily altered

#04-001 APPROVAL DATE APR 29 2004

SUPERSEDES TN #00-014 EFFECTIVE DATE 01/08/04

Resident Identifier _____ Numeric Identifier _____

E4. BEHAVIORAL SYMPTOMS

(A) *Behavioral symptom frequency in last 7 days*
0. Behavior not exhibited in last 7 days
1. Behavior of this type occurred 1 to 3 days in last 7 days
2. Behavior of this type occurred 4 to 6 days, but less than daily
3. Behavior of this type occurred daily

(B) *Behavioral symptom alterability in last 7 days*
0. Behavior not present OR behavior was easily altered
1. Behavior was not easily altered

	(A)	(B)
a. WANDERING (moved with no rational purpose, seemingly obvious to needs or safety)		
b. VERBALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were threatened, screamed at, cursed at)		
c. PHYSICALLY ABUSIVE BEHAVIORAL SYMPTOMS (others were hit, shoved, scratched, sexually abused)		
d. SOCIALLY INAPPROPRIATE/DISRUPTIVE BEHAVIORAL SYMPTOMS (made disruptive sounds, noisiness, screaming, self-abusive acts, sexual behavior or disrobing in public, smeared/threw food/feces, hoarding, rummaged through others' belongings)		
e. RESISTS CARE (resisted taking medications/injections, ADL assistance, or eating)		

G1. (A) ADL SELF-PERFORMANCE—*(Code for resident's PERFORMANCE OVER ALL SHIFTS during last 7 days—Not including setup)*

0. *INDEPENDENT*—No help or oversight —OR— Help/oversight provided only 1 or 2 times during last 7 days
1. *SUPERVISION*—Oversight, encouragement or cueing provided 3 or more times during last 7 days —OR— Supervision (3 or more times) plus physical assistance provided only 1 or 2 times during last 7 days
2. *LIMITED ASSISTANCE*—Resident highly involved in activity; received physical help in guided maneuvering of limbs or other nonweight bearing assistance 3 or more times —OR—More help provided only 1 or 2 times during last 7 days
3. *EXTENSIVE ASSISTANCE*—While resident performed part of activity, over last 7-day period, help of following type(s) provided 3 or more times:
— Weight-bearing support
— Full staff performance during part (but not all) of last 7 days
4. *TOTAL DEPENDENCE*—Full staff performance of activity during entire 7 days
8. *ACTIVITY DID NOT OCCUR* during entire 7 days

(B) ADL SUPPORT PROVIDED—*(Code for MOST SUPPORT PROVIDED OVER ALL SHIFTS during last 7 days; code regardless of resident's self-performance classification)*

0. No setup or physical help from staff
1. Setup help only
2. One person physical assist
3. Two+ persons physical assist
8. ADL activity itself did not occur during entire 7days

			(A) SELF-PERF	(B) SUPPORT
a.	BED MOBILITY	How resident moves to and from lying position, turns side to side, and positions body while in bed		
b.	TRANSFER	How resident moves between surfaces—to/from: bed, chair, wheelchair, standing position (EXCLUDE to/from bath/toilet)		
c.	WALK IN ROOM	How resident walks between locations in his/her room		
d.	WALK IN CORRIDOR	How resident walks in corridor on unit		
e.	LOCOMOTION ON UNIT	How resident moves between locations in his/her room and adjacent corridor on same floor. If in wheelchair, self-sufficiency once in chair		
f.	LOCOMOTION OFF UNIT	How resident moves to and returns from off unit locations (e.g., areas set aside for dining, activities, or treatments). **If facility has only one floor**, how resident moves to and from distant areas on the floor. If in wheelchair, self-sufficiency once in chair		
g.	DRESSING	How resident puts on, fastens, and takes off all items of clothing, including donning/removing prosthesis		
h.	EATING	How resident eats and drinks (regardless of skill). Includes intake of nourishment by other means (e.g., tube feeding, total parenteral nutrition)		
i.	TOILET USE	How resident uses the toilet room (or commode, bedpan, urinal); transfer on/off toilet, cleanses, changes pad, manages ostomy or catheter, adjusts clothes		
j.	PERSONAL HYGIENE	How resident maintains personal hygiene, including combing hair, brushing teeth, shaving, applying makeup, washing/drying face, hands, and perineum (EXCLUDE baths and showers)		

G2 BATHING — How resident takes full-body bath/shower, sponge bath, and transfers in/out of tub/shower (EXCLUDE washing of back and hair.) *Code for most dependent in self-performance.*

(A) BATHING SELF PERFORMANCE codes appear below — (A)

0. Independent—No help provided
1. Supervision—Oversight help only
2. Physical help limited to transfer only
3. Physical help in part of bathing activity
4. Total dependence
8. Activity itself did not occur during entire 7 days

G3. TEST FOR BALANCE (see training manual)

(Code for ability during test in the last 7 days)
0. Maintained position as required in test
1. Unsteady, but able to rebalance self without physical support
2. Partial physical support during test; or stands (sits) but does not follow directions for test
3. Not able to attempt test without physical help

a. Balance while standing
b. Balance while sitting—position, trunk control

G4. FUNCTIONAL LIMITATION IN RANGE OF MOTION

(Code for limitations during last 7 days that interfered with daily functions or placed residents at risk of injury)
(A) *RANGE OF MOTION*: 0. No limitation; 1. Limitation on one side; 2. Limitation on both sides
(B) *VOLUNTARY MOVEMENT*: 0. No loss; 1. Partial loss; 2. Full loss

	(A)	(B)
a. Neck		
b. Arm—including shoulder or elbow		
c. Hand—including wrist or fingers		
d. Leg—including hip or knee		
e. Foot—including ankle or toes		
f. Other limitation or loss		

G5. MODES OF LOCOMOTION

(Check if applied during last 7 days)
b. Wheeled self ☐

G6. MODES OF TRANSFER

(Check all that apply during last 7 days)
a. Bedfast all or most of time ☐
b. Bed rails used for bed mobility or transfer ☐

G7. TASK SEGMENTATION

Some or all of ADL activities were broken into subtasks during last 7 days so that resident could perform them
0. No 1. Yes

H1. CONTINENCE SELF-CONTROL CATEGORIES
(Code for resident's PERFORMANCE OVER ALL SHIFTS)

0. *CONTINENT*—*Complete control [includes use of indwelling urinary catheter or ostomy device that does not leak urine or stool]*
1. *USUALLY CONTINENT*—BLADDER, incontinent episodes once a week or less; BOWEL, less than weekly
2. *OCCASIONALLY INCONTINENT*—BLADDER, 2 or more times a week but not daily; BOWEL, once a week
3. *FREQUENTLY INCONTINENT*—BLADDER, tended to be incontinent daily, but some control present (e.g.. on day shift); BOWEL, 2-3 times a week
4. *INCONTINENT*—Had inadequate control BLADDER, multiple daily episodes; BOWEL, all (or almost all) of the time

a.	BOWEL CONTINENCE	Control of bowel movement, with appliance or bowel continence programs, if employed
b.	BLADDER CONTINENCE	Control of urinary bladder function (if dribbles, volume insufficient to soak through underpants), with appliances (e.g., foley) or continence programs, if employed

H2. BOWEL ELIMINATION PATTERN
c. Diarrhea
d. Fecal impaction

H3. APPLIANCES AND PROGRAMS
a. Any scheduled toileting plan
b. Bladder retraining program
c. External (condom) catheter
d. Indwelling catheter
i. Ostomy present

For Section I : check only those diseases that have a relationship to current ADL status, cognitive status, mood and behavior status, medical treatments, nursing monitoring, or risk of death. (Do not list inactive diagnoses)

I1. DISEASES

a.	Diabetes melitus	v.	Hemiplegia/Hemiparesis
d.	Arteriosclerotic heart disease (ASHD)	w.	Multiple sclerosis
f.	Congestive heart failure	x.	Paraplegia
j.	Peripheral vascular disease	z.	Quadriplegia
m.	Hip fracture	ee.	Depression
r.	Aphasia	ff.	Manic depressive (bipolar disease)
s.	Cerebral palsy	gg.	Schizophrenia
t.	Cerebrovascular accident (stroke)	hh.	Asthma
		ii.	Emphysema/COPD

I2. INFECTIONS *(If none apply, CHECK the NONE OF ABOVE box)*

a.	Antibiotic resitant infection (e.g. Methicillin resistant staph)	g.	Septicemia
b.	Clostridium difficile (c. diff.)	h.	Sexually transmitted diseases
c.	Conjunctivitis	i.	Tuberculosis
d.	HIV infection	j.	Urinary tract infection in last 30 days
e.	Pneumonia	k.	Viral hepatitis
f.	Respiratory infection	l.	Wound infection
			NONE OF ABOVE

SUPERSEDES